

MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

**Mortality Attributable to HIV Infection/AIDS —
United States, 1981–1990**

From 1981 through 1990, 100,777 deaths among persons with acquired immunodeficiency syndrome (AIDS) were reported to CDC by local, state, and territorial health departments; almost one third (31,196) of these deaths were reported during 1990.* During the 1980s, AIDS emerged as a leading cause of death among young adults in the United States. By 1988,[†] human immunodeficiency virus (HIV) infection/AIDS had become the third leading cause of death among men 25–44 years of age and, by 1989, was estimated to be second, surpassing heart disease, cancer, suicide, and homicide (Figure 1). In 1988, HIV infection/AIDS ranked eighth among causes of death among women 25–44 years of age (Figure 2); in 1991, based on current trends, HIV infection/AIDS is likely to rank among the five leading causes of death in this population (1).

Most deaths from AIDS have occurred among homosexual/bisexual men (men who have had sex with other men) (59%) and among women and heterosexual men who are intravenous-drug users (21%) (Table 1). Nearly three fourths of deaths occurred among persons 25–44 years of age. Although most deaths occurred among whites, death rates have been highest for blacks and Hispanics. During 1990, the number of reported deaths (national AIDS surveillance) per 100,000 population was 29.3 for blacks (non-Hispanic), 22.2 for Hispanics, 8.7 for whites (non-Hispanic), 2.8 for Asian/Pacific Islanders, and 2.8 for American Indians/Alaskan Natives.

As a percentage of all deaths, HIV infection/AIDS mortality has been greatest among persons 25–44 years of age. In 1989, among persons in this age group, HIV infection/AIDS accounted for 14% and 4% of all deaths among men and women, respectively; these proportions were more similar for white men and black men (14% and 16%, respectively) than for white women and black women (2% and 9%, respectively) (2).

*Single copies of this article will be available free until January 25, 1992, from the National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850; telephone (800) 458-5231.

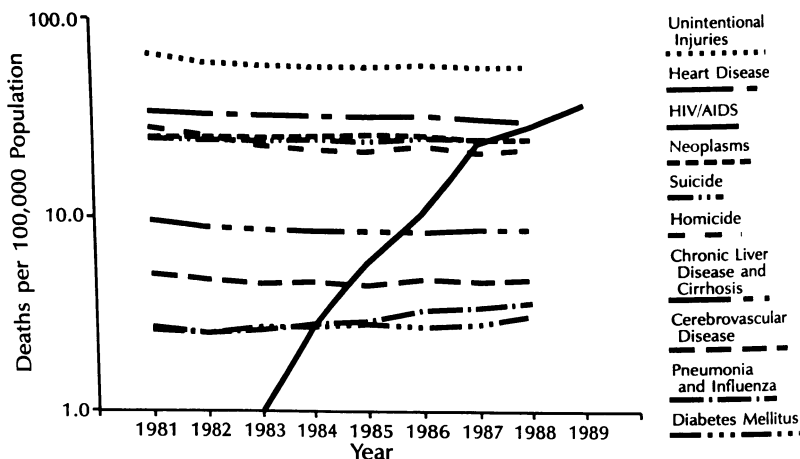
[†]The most recent year for which national vital statistics data are available to compare rankings of HIV infection/AIDS with other causes of death by age and sex. Vital statistics data in this report represent deaths for which HIV infection or AIDS was designated as the underlying cause of death.

HIV Infection/AIDS – Continued

Reported by: Local, state, and territorial health departments. Div of HIV/AIDS, Center for Infectious Diseases; Div of Vital Statistics, National Center for Health Statistics, CDC.

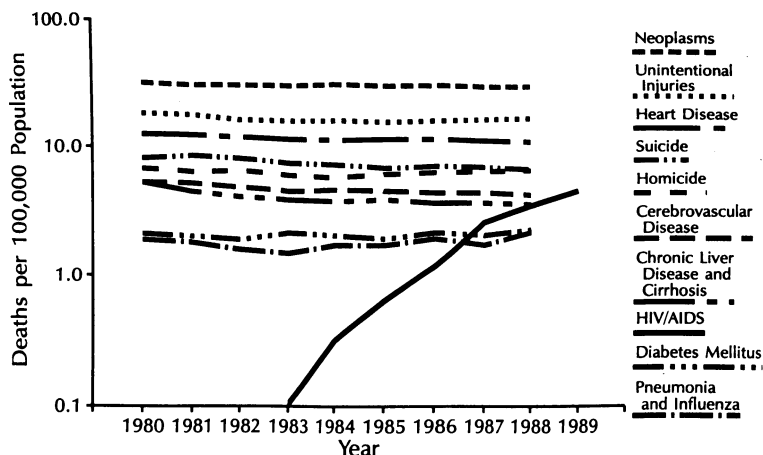
Editorial Note: From 1981, when AIDS was first recognized, through 1990, more than 100,000 persons in the United States have died from AIDS. The impact of AIDS has been greatest among men 25–44 years of age, contributing substantially to the overall increase in deaths among this group during the 1980s (3); in addition, AIDS is becoming a leading cause of death among women.

FIGURE 1. Leading causes of death among men 25–44 years of age – United States, 1981–1989*



*National vital statistics. Final data for 1981–1988; provisional data for HIV infection/AIDS for 1989.

FIGURE 2. Leading causes of death among women 25–44 years of age – United States, 1980–1989*



*National vital statistics. Final data for 1980–1988; provisional data for HIV infection/AIDS for 1989.

HIV Infection/AIDS – Continued

The impact of AIDS on mortality patterns has been greater in certain areas of the United States than in others. For example, in San Francisco, Los Angeles, and New York City, HIV infection/AIDS is the leading cause of death among young adult men. In both New York State and New Jersey, HIV infection/AIDS is the leading cause of death among black women 15–44 years of age; in New Jersey, the number of deaths among this population from HIV infection/AIDS in 1988 was nearly equal to the

TABLE 1. Characteristics of persons who have died from AIDS – United States, 1981–1990

Characteristic	No.	(%)
Total	100,777	(100.0)
HIV exposure group		
Homosexual/Bisexual men	59,586	(59.1)
Intravenous-drug users		
Women and heterosexual men	21,126	(21.0)
Homosexual/Bisexual men	6,894	(6.8)
Persons with hemophilia		
Adult/Adolescent	945	(0.9)
Child	74	(0.1)
Transfusion recipient		
Adult/Adolescent	2,793	(2.8)
Child	150	(0.1)
Heterosexual contact	3,587	(3.6)
Persons born in countries where		
HIV infection occurs primarily		
through heterosexual contact	1,160	(1.2)
Perinatal	1,186	(1.2)
No identified risk	3,276	(3.3)
Race/Ethnicity		
White, non-Hispanic	55,494	(55.1)
Black, non-Hispanic	28,575	(28.4)
Hispanic	15,805	(15.7)
Asian/Pacific Islander	608	(0.6)
American Indian/Alaskan Native	138	(0.1)
Unspecified	157	(0.2)
Age at death (yrs)		
<5	1,141	(1.1)
5–14	308	(0.3)
15–24	3,266	(3.2)
25–34	36,418	(36.1)
35–44	37,634	(37.3)
45–54	14,256	(14.1)
≥55	7,405	(7.3)
Unspecified	349	(0.3)
Sex		
Male	90,715	(90.0)
Female	10,056	(10.0)
Unspecified	6	(<0.1)

Source: National AIDS surveillance.

HIV Infection/AIDS — Continued

number of deaths from the second and third leading causes combined (cancer and unintentional injuries) (1; CDC, unpublished data). In some locations, HIV infection/AIDS has become a major cause of death among young children; in New York State in 1988, HIV infection/AIDS was the leading cause of death among Hispanic children 1–4 years of age, and the second leading cause of death among black children 1–4 years of age, exceeding deaths from unintentional injuries among Hispanic children and from all other infectious diseases among both groups (4).

Surveillance for AIDS cannot identify deaths among persons in whom HIV infection or HIV-related illness has not been diagnosed; however, AIDS surveillance does identify most deaths among persons diagnosed as having HIV infection. From July 1986 through June 1987, 3001 death certificates listing diagnoses that indicate HIV infection/AIDS were filed in New York City; of the deaths registered by these certificates, 85% were among persons who met the CDC AIDS surveillance case definition, 6% among persons who would have met the definition if HIV serology results had been available, and 9% among HIV-infected persons with illnesses or conditions not included in the AIDS surveillance definition (5). When the effects of underdiagnosis and underreporting are considered, AIDS surveillance identifies 70%–90% of HIV-infection-related deaths and, therefore, provides a minimum estimate of HIV-infection-related mortality (3; CDC, unpublished data).

In addition to mortality statistics, measures of the public health impact of HIV infection/AIDS include morbidity, disability, and health-care costs. For example, the HIV infection/AIDS epidemic is straining the resources of public hospitals (6); in 1989, private insurers paid more than an estimated one billion dollars for reimbursement of AIDS-related claims for life and health insurance, an increase of 71% from 1988 (7).

An estimated one million persons in the United States are infected with HIV (8); of these, an estimated 165,000–215,000 will die during 1991–1993 (8). The impact of HIV infection/AIDS on mortality in the mid-1990s to late 1990s and early 2000s will depend on present efforts to prevent and treat HIV infection.

References

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Update: Influenza Activity – United States, 1990–91

During December 1990 (weeks 48–52) and January 1991 (weeks 1 and 2), influenza and influenza-like illness activity were higher in the United States than in previous weeks (Table 1). As of January 18, >95% of the approximately 125 influenza virus isolates reported to CDC have been influenza B. Deaths associated with pneumonia and influenza are at levels expected for this time of year.

During December, a small number of outbreaks of influenza-like illnesses were reported in schools and colleges in the northeastern United States. Through January 18, there have been no reports of outbreaks in chronic-care facilities or nursing homes.

Reported by: State and territorial health department epidemiologists and state public health laboratory directors. WHO Collaborating Laboratories. Sentinel Physicians Influenza Surveillance System of the American Academy of Family Practice. Epidemiology Office and Influenza Br, Div of Viral and Rickettsial Diseases, Center for Infectious Diseases, CDC.

Editorial Note: During the 1989–90 influenza season, widespread influenza outbreaks occurred during December 1989, and influenza A(H3N2) was the predominant virus isolated. Although influenza B has been the predominant virus isolated this season, culturing for influenza viruses remains important in the evaluation of respiratory illnesses in high-risk persons, especially those in group living situations, because amantadine may be useful in treatment and prophylaxis if influenza A is identified (1). Amantadine is effective against influenza A but not against influenza B. Parents and health-care workers should consult a physician before administering aspirin to children with influenza and influenza-like illness because its use may increase the risk for Reye syndrome (2).

TABLE 1. Influenza and influenza-like illness (ILI)* activity† – October 1990–January 1991

Week	% Patients with ILI [‡]	No. states reporting activity		
		Sporadic	Regional	Widespread
40–46	3.5	4–10	0	0
47	4.7	9	0	0
48	4.4	14	0	0
49	4.6	11	2	0
50	4.7	16	4	0
51	5.7	16	2	0
52	6.8	16	4	0
1	5.9	17	8	0
2	—	18	8	1

*Illness with fever (temperature ≥ 100 F [≥ 37.8 C]) and cough, myalgia, or sore throat.

†Levels of activity are: 1) *sporadic*—sporadically occurring influenza-like illness or culture-confirmed influenza, with no outbreaks detected; 2) *regional*—outbreaks of influenza-like illness or culture-confirmed influenza in counties having a combined population of <50% of the state's total population; 3) *widespread*—outbreaks of influenza-like illness or culture-confirmed influenza in counties having a combined population of $\geq 50\%$ of the state's total population.

‡Approximately 150 physicians in 48 states report number of patients seen and number of patients with ILI each week.

*Influenza Activity — Continued**References*

1. ACIP. Prevention and control of influenza. MMWR 1990;39(no. RR-7).
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*Epidemiologic Notes and Reports***Laboratory-Acquired Meningococcemia —
California and Massachusetts**

Although *Neisseria meningitidis* is commonly isolated in clinical laboratories, laboratory-acquired infection is rare (1). This report describes two fatal cases of meningococcal infection in laboratory workers; both of these cases probably were laboratory acquired.

Case 1. On March 8, 1988, a clinical laboratory bacteriologist in California became ill with influenza-like symptoms and nausea. During the next 24 hours, she developed fever, myalgias, arthralgias, diarrhea, skin lesions, and confusion. Her husband informed ambulance personnel that she had had a mishap in the laboratory approximately 1 week earlier with a type of organism that causes meningitis.

When hospitalized at 10 p.m. on March 9, she was hypotensive with numerous petechial and purpuric lesions on her face, neck, trunk, and extremities; she died 6 hours later. The final autopsy diagnosis was "clinical acute intractable shock, consistent with acute meningococcemia." Blood cultures and cerebrospinal fluid studies were negative. Serum was positive by a bivalent (groups C and W135) latex agglutination test for *N. meningitidis*. A throat culture grew *N. meningitidis*.

No mishap had been reported at the hospital laboratory where the patient worked, nor could the patient's co-workers recall any episode; no additional information regarding a mishap could be discovered. During the previous 3 months, the patient worked with only one known *N. meningitidis* isolate, which was obtained from the blood of a patient with acute meningitis and cultured by the affected laboratory worker 5-6 days before onset of her symptoms. Both the workplace isolate and the laboratory worker's nasopharyngeal isolate were identified as *N. meningitidis* serogroup C by the Microbial Diseases Laboratory of the California Department of Health Services.

CDC performed isoenzyme testing on the laboratory worker's nasopharyngeal isolate, the workplace isolate, and 14 other unrelated but recently isolated group C strains from throughout northern California. The isoenzyme type of the laboratory worker's isolate and the workplace isolate were identical and rare. They differed from the 14 northern California isolates ($p < 0.01$, Fisher's exact test) and from a collection of 256 group C meningococci isolated between 1986 and 1989 ($p < 0.01$, Fisher's exact test).

Case 2. On the morning of September 6, 1988, a microbiology technician at a teaching hospital in Massachusetts presented to the hospital's employee health clinic with a history of several days of rhinorrhea, sore throat, and myalgias. She was sent home at 1 p.m. with a diagnosis of viral syndrome. Twelve hours later, she presented to the emergency room semiresponsive, hypotensive, dyspneic, and with petechial

Meningococcemia — Continued

and purpuric skin lesions. A gram stain of the buffy coat of her blood showed gram negative diplococci. Despite antibiotic therapy, she died 6½ hours later. Blood cultures grew *N. meningitidis* group B.

For several days before her hospitalization the patient had been working in the bacteriology laboratory at the teaching hospital despite her upper respiratory infection symptoms. The laboratory had not isolated *N. meningitidis* during the 3 weeks before the patient's illness. On September 3 and 4, the patient worked in the bacteriology laboratory of another hospital. She had been observed using gloves to subculture an *N. meningitidis* isolate, and she had extensive rhinorrhea.

Both the workplace isolate and the patient's blood culture isolate were identified as *N. meningitidis* serogroup B. Isoenzyme testing performed by CDC on the patient's blood isolate, the workplace isolate, and nine other unrelated but recently isolated group B strains from Massachusetts demonstrated that the isoenzyme pattern of the patient and workplace isolate were identical. They differed from the nine other Massachusetts group B isolates ($p < 0.02$, Fisher's exact test).

Reported by: KK Takata, BG Hinton, MD, Sacramento County Health Dept; SB Werner, MD, Infectious Disease Br, Preventive Medical Svcs Div; GW Rutherford, MD, State Epidemiologist, California Dept of Health Svcs. SM Lett, MD, Bur of Communicable Disease Control, Center for Disease Control, Massachusetts Dept of Public Health. Biosafety Br, Office of Health and Safety; Meningitis and Special Pathogens Br, Div of Bacterial and Mycotic Diseases, Center for Infectious Diseases, CDC.

Editorial Note: Laboratory-acquired infection with *N. meningitidis* is rare. Three previous case reports describe infections in persons working in research laboratories who handled meningococcal organisms frequently and in large volumes (1,2); two of these occurred before the availability of effective vaccines and antibiotic therapy.

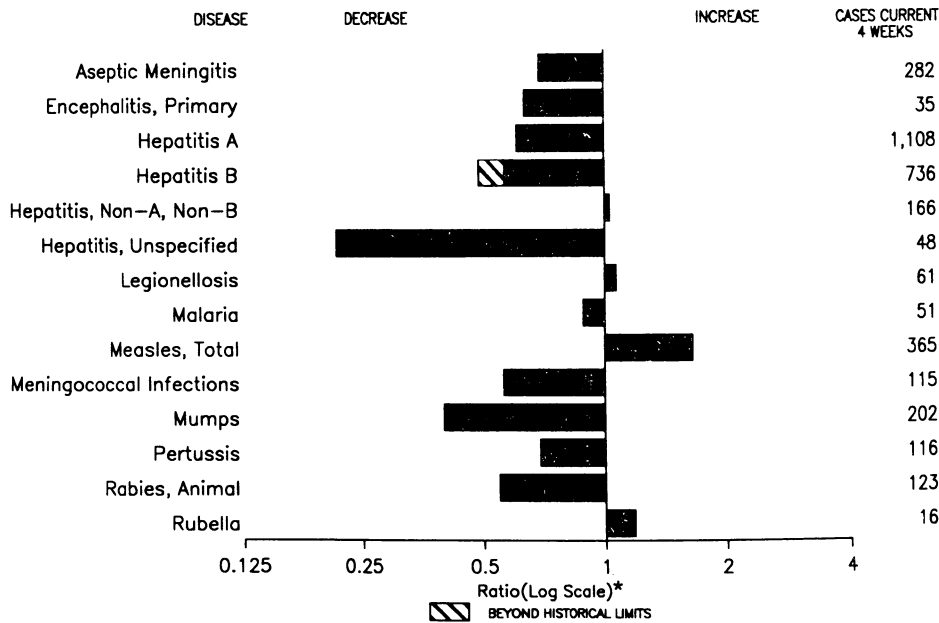
Although *N. meningitidis* was never isolated from the blood of the laboratory worker in California, other evidence supports the conclusion that she had laboratory-acquired meningococcal infection. The worker in Massachusetts may have been at increased risk for meningococcal infection; several studies suggest that concurrent viral infection increases the risk of developing invasive meningococcal infection (3-5).

These cases represent the first reports of meningococcal infection acquired in the clinical laboratory setting. Although laboratory workers frequently handle specimens and cultures containing meningococci, the laboratory workers probably are not at increased risk of infection when standard microbiologic practices are followed.

Meningococci may be present in specimens of pharyngeal exudates, cerebrospinal fluid, blood, and saliva. Laboratory workers may be exposed to organisms by inoculation, ingestion, and droplet or aerosol exposure of the mucous membranes. Guidelines for laboratory workers who handle meningococci include use of protective gloves and laboratory coats and decontamination of all infectious wastes (6). A class II biological safety cabinet should be used when mechanical manipulations that have high aerosol potential are performed. Work involving high concentrations or large quantities of organisms should be performed in a biosafety level 3 laboratory; laboratory workers in this setting should be immunized with the tetravalent meningococcal polysaccharide vaccine that includes serogroups A, C, Y, and W135 but does not include serogroup B, currently the most common serogroup in the United States. In the event of any incident or exposure involving meningococci, workers should seek prompt medical attention. Persons with percutaneous exposure to meningococci should receive chemoprophylaxis with penicillin; those with mucosal exposure should be treated with rifampin (7).

(Continued on page 55)

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending January 19, 1991, with historical data — United States



*Ratio of current 4-week total to mean of 15 4-week totals (from comparable, previous, and subsequent 4-week periods for past 5 years).

TABLE I. Summary — cases of specified notifiable diseases, United States, cumulative, week ending January 19, 1991 (3rd Week)

	Cum. 1991		Cum. 1991
AIDS	1,757	Plague	-
Anthrax	-	Poliomyelitis, Paralytic*	-
Botulism: Foodborne	-	Psittacosis	1
Infant	4	Rabies, human	-
Other	-	Syphilis: civilian	1,672
Brucellosis	1	military	2
Cholera	-	Syphilis, congenital, age < 1 year	-
Congenital rubella syndrome	-	Tetanus	-
Diphtheria	-	Toxic shock syndrome	17
Encephalitis, post-infectious	1	Trichinosis	1
Gonorrhea: civilian	24,485	Tuberculosis	895
military	290	Tularemia	4
Leprosy	8	Typhoid fever	4
Leptospirosis	-	Typhus fever, tickborne (RMSF)	4
Measles: imported	5		
indigenous	86		

*No cases of suspected poliomyelitis have been reported in 1991; none of the 6 suspected cases in 1990 have been confirmed to date. Five of the 13 suspected cases in 1989 were confirmed and all were vaccine associated.

TABLE II. Cases of specified notifiable diseases, United States, weeks ending January 19, 1991, and January 20, 1990 (3rd Week)

Reporting Area	AIDS	Aseptic Menin- gitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionel- losis	Leprosy
			Primary	Post-in- fectious			A	B	NA,NB	Unspeci- fied		
	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991
UNITED STATES	1,757	207	23	1	24,485	37,839	848	584	141	38	39	8
NEW ENGLAND	136	9	2	-	1,000	1,147	25	46	7	3	5	-
Maine	11	-	1	-	5	12	1	1	1	-	-	-
N.H.	-	-	-	-	-	13	1	4	1	-	1	-
Vt.	3	-	-	-	4	5	-	-	-	-	-	-
Mass.	70	4	1	-	402	352	17	36	5	2	4	-
R.I.	6	5	-	-	42	60	6	5	-	1	-	-
Conn.	46	-	-	-	547	705	-	-	-	-	-	-
MID. ATLANTIC	204	11	1	-	2,213	3,806	43	28	2	-	3	-
Upstate N.Y.	93	8	-	-	456	522	32	14	1	-	-	-
N.Y. City	17	-	-	-	-	2,056	-	-	-	-	-	-
N.J.	90	-	-	-	575	721	-	-	-	-	-	-
Pa.	4	3	1	-	1,182	507	11	14	1	-	3	-
E.N. CENTRAL	117	27	1	1	3,536	7,957	44	61	22	6	8	-
Ohio	-	14	-	1	-	2,867	26	22	7	3	6	-
Ind.	-	1	-	-	681	823	5	6	-	-	-	-
Ill.	102	-	-	-	1,380	1,984	-	-	-	-	-	-
Mich.	-	12	1	-	1,382	1,775	8	28	5	3	2	-
Wis.	15	-	-	-	93	508	5	5	10	-	-	-
W.N. CENTRAL	134	26	2	-	1,298	2,175	139	11	6	-	2	-
Minn.	34	7	1	-	155	243	2	-	-	-	-	-
Iowa	14	4	-	-	104	225	4	1	-	-	-	-
Mo.	78	2	-	-	621	1,069	6	2	2	-	-	-
N. Dak.	-	-	-	-	-	20	-	-	-	-	-	-
S. Dak.	-	2	1	-	13	9	99	-	-	-	-	-
Nebr.	4	5	-	-	153	4	18	5	-	-	2	-
Kans.	4	6	-	-	252	605	10	3	4	-	-	-
S. ATLANTIC	521	64	6	-	8,780	11,705	38	127	20	2	7	-
Del.	5	2	-	-	86	134	4	4	1	-	-	-
Md.	1	10	2	-	1,071	1,189	10	18	7	1	1	-
D.C.	40	3	-	-	355	683	1	4	-	-	-	-
Va.	23	4	-	-	475	1,182	3	7	-	-	-	-
W. Va.	3	-	1	-	78	102	2	2	-	1	-	-
N.C.	40	36	2	-	1,627	2,178	10	38	11	-	3	-
S.C.	21	2	-	-	706	1,249	4	32	1	-	2	-
Ga.	105	-	1	-	2,495	2,579	1	16	-	-	1	-
Fla.	283	7	-	-	1,887	2,409	3	6	-	-	-	-
E.S. CENTRAL	58	9	1	-	2,193	3,050	14	58	27	-	4	-
Ky.	-	5	-	-	301	287	3	16	1	-	3	-
Tenn.	28	2	1	-	437	696	7	38	26	-	1	-
Ala.	29	1	-	-	908	1,362	4	4	-	-	-	-
Miss.	1	1	-	-	547	705	-	-	-	-	-	-
W.S. CENTRAL	209	25	3	-	2,006	2,830	41	46	4	1	1	2
Ark.	-	23	-	-	314	603	8	-	-	-	-	-
La.	4	-	-	-	425	581	8	24	1	-	1	-
Okla.	5	1	3	-	308	294	21	20	3	1	-	-
Tex.	200	1	-	-	959	1,352	4	2	-	-	-	2
MOUNTAIN	17	7	1	-	510	871	157	46	8	3	8	-
Mont.	-	-	-	-	4	8	10	7	-	2	-	-
Idaho	-	-	-	-	4	3	3	2	-	-	-	-
Wyo.	2	-	-	-	4	6	1	-	-	-	-	-
Colo.	1	1	-	-	-	248	3	3	1	1	-	-
N. Mex.	10	-	-	-	50	42	47	1	-	-	-	-
Ariz.	-	2	1	-	301	376	64	20	3	-	2	-
Utah	4	2	-	-	25	27	21	3	2	-	4	-
Nev.	-	2	-	-	122	161	8	10	2	-	2	-
PACIFIC	361	29	6	-	2,949	4,298	347	161	45	23	1	6
Wash.	34	-	-	-	150	413	38	27	3	1	-	-
Oreg.	-	-	-	-	122	155	21	11	4	1	-	-
Calif.	325	28	6	-	2,615	3,644	281	119	37	21	1	6
Alaska	2	-	-	-	47	74	4	3	1	-	-	-
Hawaii	-	1	-	-	15	12	3	1	-	-	-	-
Guam	-	-	-	-	-	10	-	-	-	-	-	-
P.R.	61	-	-	-	-	101	-	-	-	-	-	-
V.I.	-	-	-	-	28	27	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	-	4	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	8	-	-	-	-	-	-

N: Not notifiable

U: Unavailable

C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE II. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending January 19, 1991, and January 20, 1990 (3rd Week)

Reporting Area	Malaria	Measles (Rubeola)					Men- gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1991	1991	Cum. 1991	1991	Cum. 1991	Cum. 1990	Cum. 1991	1991	Cum. 1991	1991	Cum. 1991	Cum. 1990	1991	Cum. 1991	Cum. 1990
UNITED STATES	33	40	86	3	5	617	64	45	102	30	75	151	3	8	19
NEW ENGLAND	4	-	-	-	-	5	6	-	1	1	7	30	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-
N.H.	-	-	-	-	-	-	2	-	-	1	6	-	-	-	-
Vt.	-	-	-	-	-	-	1	-	-	-	-	1	-	-	-
Mass.	3	-	-	-	-	-	3	-	-	-	-	28	-	-	-
R.I.	1	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Conn.	-	-	-	-	-	5	-	-	-	-	-	-	-	-	-
MID. ATLANTIC	-	25	28	-	-	26	5	5	11	14	20	15	-	-	-
Upstate N.Y.	-	-	-	-	-	3	2	3	3	5	5	3	-	-	-
N.Y. City	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
N.J.	-	-	3	-	-	6	-	-	-	-	1	6	-	-	-
Pa.	-	25	25	-	-	17	3	2	8	9	14	6	-	-	-
E.N. CENTRAL	-	1	1	-	-	439	3	2	9	-	8	58	-	-	3
Ohio	-	-	-	-	-	-	1	-	-	-	7	-	-	-	-
Ind.	-	-	-	-	-	3	-	-	-	-	-	26	-	-	-
Ill.	-	-	-	-	-	178	-	-	-	-	-	10	-	-	3
Mich.	-	1	1	-	-	76	2	2	8	-	1	7	-	-	-
Wis.	-	-	-	-	-	182	-	-	1	-	-	15	-	-	-
W.N. CENTRAL	-	-	-	-	-	30	3	1	6	1	9	4	-	1	-
Minn.	-	-	-	-	-	-	-	-	1	-	5	1	-	1	-
Iowa	-	-	-	-	-	19	-	1	2	1	2	-	-	-	-
Mo.	-	-	-	-	-	11	-	-	-	-	1	2	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-
Nebr.	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-
Kans.	-	-	-	-	-	-	2	-	3	-	-	-	-	-	-
S. ATLANTIC	6	-	1	-	-	10	15	14	35	1	1	15	1	3	-
Del.	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-
Md.	2	-	-	-	-	8	3	9	25	-	-	5	1	3	-
D.C.	-	-	-	-	-	-	-	-	3	-	-	1	-	-	-
Va.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
W. Va.	-	-	-	-	-	1	-	3	4	1	1	1	-	-	-
N.C.	-	-	-	-	-	-	1	-	1	-	-	1	-	-	-
S.C.	1	-	-	-	-	-	5	-	-	-	-	3	-	-	-
Ga.	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fla.	1	-	1	-	-	1	2	-	-	-	-	2	-	-	-
E.S. CENTRAL	1	-	-	-	-	11	9	-	1	1	2	7	-	-	-
Ky.	-	-	-	-	-	-	2	-	-	-	-	-	-	-	-
Tenn.	-	-	-	-	-	8	2	-	-	-	-	1	-	-	-
Ala.	1	-	-	-	-	-	5	-	1	1	1	6	-	-	-
Miss.	-	-	-	-	-	3	-	-	1	1	1	-	-	-	-
W.S. CENTRAL	1	-	-	3	4	-	4	3	3	4	5	1	-	-	-
Ark.	-	-	-	3 [§]	4	-	-	-	-	-	-	-	-	-	-
La.	1	-	-	-	-	-	4	1	1	4	5	1	-	-	-
Okla.	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-
Tex.	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-
MOUNTAIN	-	3	6	-	-	6	3	7	10	3	9	3	-	1	-
Mont.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	-	-	-	-	-	1	-	1	-	3	-	-	-	-
N. Mex.	-	-	-	-	-	-	-	N	N	-	1	-	-	-	-
Ariz.	-	-	1	-	-	6	2	7	9	3	5	2	-	-	-
Utah	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-
Nev.	-	3	5	-	-	-	-	-	-	-	-	-	-	1	-
PACIFIC	21	11	50	-	1	90	16	13	26	5	14	18	2	3	16
Wash.	2	-	-	-	-	1	-	2	2	-	-	-	-	-	-
Oreg.	1	-	-	-	-	1	2	N	N	1	1	4	-	-	-
Calif.	18	11	49	-	1	88	14	9	19	3	7	12	2	3	14
Alaska	-	-	-	-	-	-	-	1	3	-	-	-	-	-	-
Hawaii	-	-	1	-	-	-	-	1	2	1	6	2	-	-	2
Guam	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-
P.R.	-	U	-	U	-	1	-	U	-	U	-	-	U	-	-
V.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-
C.N.M.I.	-	U	-	U	-	-	-	U	-	U	-	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.

N: Not notifiable U: Unavailable [†]International [§]Out-of-state

TABLE II. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending January 19, 1991, and January 20, 1990 (3rd Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic- shock Syndrome	Tuberculosis		Tula- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991	Cum. 1990	Cum. 1991	Cum. 1991	Cum. 1991	Cum. 1991
UNITED STATES	1,672	1,963	17	895	843	4	4	4	132
NEW ENGLAND	53	115	3	10	6	-	-	-	-
Maine	-	-	2	-	-	-	-	-	-
N.H.	-	23	-	-	1	-	-	-	-
Vt.	1	-	-	-	-	-	-	-	-
Mass.	34	24	1	-	-	-	-	-	-
R.I.	2	-	-	2	1	-	-	-	-
Conn.	16	68	-	8	4	-	-	-	-
MID. ATLANTIC	196	409	2	164	282	-	-	-	50
Upstate N.Y.	17	3	2	-	17	-	-	-	21
N.Y. City	-	308	-	127	228	-	-	-	-
N.J.	74	91	-	26	12	-	-	-	29
Pa.	105	7	-	11	25	-	-	-	-
E.N. CENTRAL	188	85	4	97	78	-	1	-	2
Ohio	8	22	3	39	4	-	-	-	-
Ind.	18	1	-	2	-	-	-	-	-
Ill.	131	37	-	52	67	-	-	-	-
Mich.	13	4	1	-	-	-	1	-	-
Wis.	18	21	-	4	7	-	-	-	2
W.N. CENTRAL	30	17	2	9	24	2	-	1	8
Minn.	4	5	1	-	8	-	-	-	6
Iowa	2	3	1	6	1	-	-	-	-
Mo.	24	8	-	-	6	-	-	-	-
N. Dak.	-	1	-	1	3	-	-	-	1
S. Dak.	-	-	-	-	2	-	-	-	-
Nebr.	-	-	-	-	4	-	-	-	1
Kans.	-	-	-	2	-	2	-	1	-
S. ATLANTIC	587	729	1	59	75	-	1	2	49
Del.	6	8	-	-	4	-	-	-	6
Md.	55	53	-	3	19	-	1	-	19
D.C.	37	10	-	5	-	-	-	-	-
Va.	34	56	-	7	13	-	-	-	7
W. Va.	1	1	-	6	2	-	-	-	5
N.C.	69	93	1	13	-	-	-	2	-
S.C.	78	67	-	14	24	-	-	-	2
Ga.	138	205	-	8	4	-	-	-	10
Fla.	169	236	-	3	9	-	-	-	-
E.S. CENTRAL	98	114	-	53	26	-	-	1	5
Ky.	5	-	-	-	15	-	-	-	1
Tenn.	1	-	-	-	-	-	-	-	-
Ala.	51	54	-	27	11	-	-	1	4
Miss.	41	60	-	26	-	-	-	-	-
W.S. CENTRAL	227	234	1	72	81	1	-	-	10
Ark.	9	20	-	5	19	1	-	-	3
La.	86	117	-	46	51	-	-	-	-
Okla.	11	11	1	-	-	-	-	-	3
Tex.	121	86	-	21	11	-	-	-	4
MOUNTAIN	37	20	-	39	9	-	-	-	2
Mont.	-	-	-	-	-	-	-	-	1
Idaho	-	1	-	-	-	-	-	-	-
Wyo.	1	-	-	-	-	-	-	-	-
Colo.	-	4	-	6	-	-	-	-	-
N. Mex.	-	-	-	-	4	-	-	-	-
Ariz.	36	14	-	22	3	-	-	-	1
Utah	-	1	-	10	-	-	-	-	-
Nev.	-	-	-	1	2	-	-	-	-
PACIFIC	256	240	4	392	262	1	2	-	6
Wash.	-	27	-	10	14	-	-	-	-
Oreg.	3	3	-	6	4	-	-	-	-
Calif.	252	209	4	366	224	1	2	-	6
Alaska	1	1	-	1	6	-	-	-	-
Hawaii	-	-	-	9	14	-	-	-	-
Guam	-	-	-	-	4	-	-	-	-
P.R.	-	31	-	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-
Amner. Samoa	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	2	-	-	-	-

U: Unavailable

**TABLE III. Deaths in 121 U.S. cities,* week ending
January 19, 1991 (3rd Week)**

Reporting Area	All Causes, By Age (Years)						P&I**	Total	Reporting Area	All Causes, By Age (Years)						P&I**	Total
	All Ages	≥65	45-64	25-44	1-24	<1				All Ages	≥65	45-64	25-44	1-24	<1		
NEW ENGLAND	682	503	101	45	17	15	60		S. ATLANTIC	1,410	864	297	150	43	53	91	
Boston, Mass.	175	114	30	19	7	5	16		Atlanta, Ga.	200	130	42	21	4	3	11	
Bridgeport, Conn.	55	42	6	4	-	3	7		Baltimore, Md.	252	154	55	33	8	2	21	
Cambridge, Mass.	23	19	4	-	-	-	2		Charlotte, N.C.	118	63	30	14	4	7	6	
Fall River, Mass.	32	29	2	-	1	-	1		Jacksonville, Fla.	141	75	35	16	8	6	8	
Hartford, Conn.	47	29	10	5	1	2	2		Miami, Fla.	107	65	29	8	4	1	1	
Lowell, Mass.	31	25	4	-	1	-	1		Norfolk, Va.	82	43	19	11	3	6	9	
Lynn, Mass.	9	6	1	1	1	-	-		Richmond, Va.	68	51	10	4	2	1	6	
New Bedford, Mass.	31	27	1	-	3	-	3		Savannah, Ga.	62	46	10	4	1	1	1	
New Haven, Conn.	60	43	12	4	-	1	7		St. Petersburg, Fla.	103	79	14	6	1	3	7	
Providence, R.I.	47	41	3	2	1	-	5		Tampa, Fla.	156	98	34	15	3	4	14	
Somerville, Mass.	11	8	3	-	-	-	-		Washington, D.C.	82	30	14	16	4	18	1	
Springfield, Mass.	43	33	5	5	-	-	4		Wilmington, Del.	39	30	5	2	1	1	6	
Waterbury, Conn.	38	29	8	1	-	-	5		E.S. CENTRAL	937	599	211	71	31	25	59	
Worcester, Mass.	80	58	12	4	2	4	7		Birmingham, Ala.	150	92	36	11	9	2	5	
MID. ATLANTIC	2,838	1,974	470	275	67	51	173		Chattanooga, Tenn.	92	62	20	5	4	1	10	
Albany, N.Y.	59	48	7	2	1	1	7		Knoxville, Tenn.	113	69	24	13	4	3	1	
Allentown, Pa.	20	14	2	1	3	-	1		Louisville, Ky.	106	67	31	3	1	4	8	
Buffalo, N.Y.‡	U	U	U	U	U	U	U		Memphis, Tenn.	215	138	46	20	7	4	20	
Camden, N.J.	27	19	1	4	-	3	2		Mobile, Ala.	82	55	16	5	3	3	2	
Elizabeth, N.J.	38	22	14	2	-	-	3		Montgomery, Ala.§	U	U	U	U	U	U	U	
Erie, Pa.†	49	36	7	3	-	3	4		Nashville, Tenn.	179	116	38	14	3	8	13	
Jersey City, N.J.	78	57	10	8	3	-	3		W.S. CENTRAL	1,535	977	318	124	47	69	100	
N.Y. City, N.Y.	1,592	1,077	266	187	33	28	68		Austin, Tex.	81	44	20	7	3	7	9	
Newark, N.J.	68	34	15	12	4	3	10		Baton Rouge, La.	47	35	6	3	1	2	4	
Paterson, N.J.	33	17	5	7	3	1	2		Corpus Christi, Tex.	80	45	18	10	5	2	4	
Philadelphia, Pa.	397	288	64	26	14	5	28		Dallas, Tex.	226	120	57	28	12	9	2	
Pittsburgh, Pa.†	86	61	13	8	2	2	8		El Paso, Tex.	79	52	19	3	1	4	8	
Reading, Pa.	38	30	8	-	-	-	6		Fort Worth, Tex.	126	96	13	9	1	7	6	
Rochester, N.Y.	117	88	18	8	-	3	10		Houston, Tex.	315	183	70	34	15	13	27	
Schenectady, N.Y.‡	U	U	U	U	U	U	U		Little Rock, Ark.	71	46	20	4	1	-	5	
Scranton, Pa.†	25	19	6	-	-	-	2		New Orleans, La.	91	66	10	2	1	12	-	
Syracuse, N.Y.	97	71	22	1	1	2	10		San Antonio, Tex.	255	166	57	16	6	10	17	
Trenton, N.J.	42	30	6	5	1	-	5		Shreveport, La.	40	26	11	2	-	1	5	
Utica, N.Y.	34	30	2	1	1	-	1		Tulsa, Okla.	124	98	17	6	1	2	13	
Yonkers, N.Y.	38	33	4	-	1	-	3		MOUNTAIN	844	552	170	78	21	23	59	
E.N. CENTRAL	3,126	2,228	519	154	85	140	151		Albuquerque, N. Mex.	83	60	17	4	1	1	3	
Akron, Ohio	77	59	8	7	2	1	-		Colo. Springs, Colo.	51	38	4	7	1	1	10	
Canton, Ohio	37	31	5	1	-	-	4		Denver, Colo.	112	75	19	11	2	5	9	
Chicago, Ill.	1,159	873	139	26	38	83	34		Las Vegas, Nev.	156	87	50	12	4	3	9	
Cincinnati, Ohio	133	91	31	5	2	4	15		Ogden, Utah	22	20	1	-	-	1	4	
Cleveland, Ohio	186	119	35	18	8	6	2		Phoenix, Ariz.	203	128	38	23	7	7	5	
Columbus, Ohio	204	136	48	12	5	3	8		Pueblo, Colo.	30	21	5	2	1	1	3	
Dayton, Ohio	128	90	24	6	4	4	12		Salt Lake City, Utah	51	29	10	9	2	1	4	
Detroit, Mich.	237	142	61	20	4	10	10		Tucson, Ariz.	136	94	26	10	3	3	12	
Evansville, Ind.	54	48	4	-	2	-	2		PACIFIC	2,196	1,491	386	199	59	52	188	
Fort Wayne, Ind.	63	50	8	4	-	1	4		Berkeley, Calif.	35	25	7	3	-	-	4	
Gary, Ind.	16	8	5	2	1	-	1		Fresno, Calif.	31	18	8	2	-	3	4	
Grand Rapids, Mich.	56	42	8	4	1	1	9		Glendale, Calif.	26	24	2	-	-	-	3	
Indianapolis, Ind.	201	132	38	18	5	8	8		Honolulu, Hawaii	91	73	11	6	1	-	14	
Madison, Wis.	48	31	10	3	3	1	4		Long Beach, Calif.	80	52	18	7	1	2	12	
Milwaukee, Wis.	155	109	27	6	5	8	13		Los Angeles, Calif.	615	413	101	64	22	6	23	
Peoria, Ill.	57	38	11	4	1	3	4		Oakland, Calif.‡	U	U	U	U	U	U	U	
Rockford, Ill.	52	30	12	6	1	3	3		Pasadena, Calif.	37	16	6	6	7	2	4	
South Bend, Ind.	71	51	15	4	1	-	6		Portland, Oreg.	166	115	30	12	3	6	4	
Toledo, Ohio	135	106	18	8	1	2	7		Sacramento, Calif.	222	145	53	13	6	5	32	
Youngstown, Ohio	57	42	12	-	1	2	5		San Diego, Calif.	167	115	28	17	5	2	23	
W.N. CENTRAL	1,006	731	180	57	12	26	54		San Francisco, Calif.	163	93	37	29	2	2	7	
Des Moines, Iowa	73	49	18	2	1	3	6		San Jose, Calif.	233	172	34	15	6	6	37	
Duluth, Minn.	23	18	3	1	1	-	-		Seattle, Wash.	172	104	35	14	3	16	7	
Kansas City, Kans.	37	26	5	3	1	2	-		Spokane, Wash.	54	43	8	2	1	-	8	
Kansas City, Mo.	148	107	29	8	2	2	3		Tacoma, Wash.	104	83	8	9	2	2	6	
Lincoln, Nebr.	30	19	8	3	-	-	2		TOTAL	14,574	9,919	2,652	1,153	382	454	935	
Minneapolis, Minn.	311	233	49	20	1	8	24										
Omaha, Nebr.	102	68	25	3	3	3	8										
St. Louis, Mo.	143	101	24	12	2	4	3										
St. Paul, Minn.	73	59	10	2	-	2	6										
Wichita, Kans.	66	51	9	3	1	2	2										

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

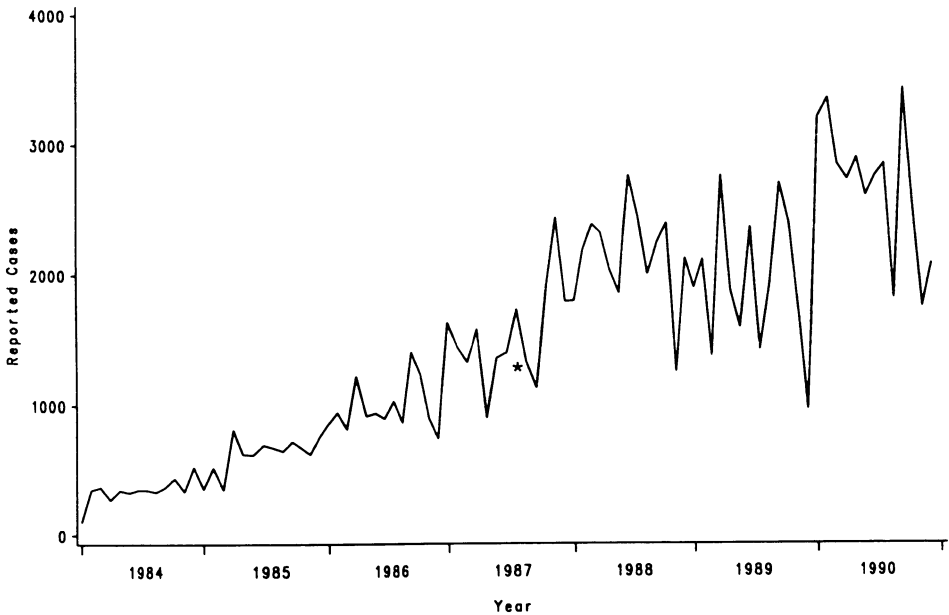
**Pneumonia and influenza.

†Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

††Total includes unknown ages.

§Report for this week is unavailable (U).

FIGURE II. Acquired immunodeficiency syndrome cases, by 4-week period of report – United States, 1984–1990



*Change in case definition.

FIGURE III. Tuberculosis cases, by 4-week period of report – United States, 1984–1990

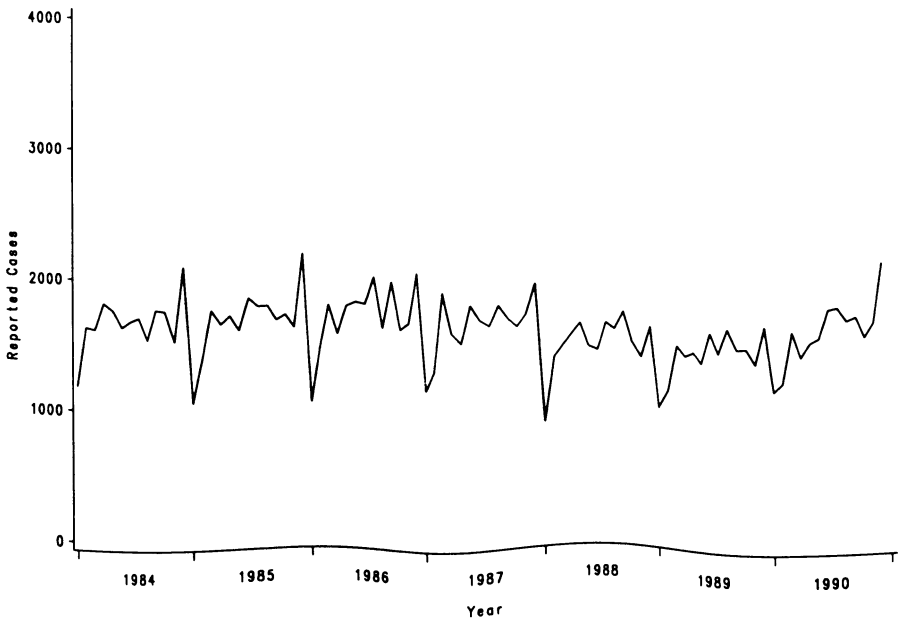


FIGURE IV. Gonorrhea cases, by 4-week period of report — United States, 1984–1990

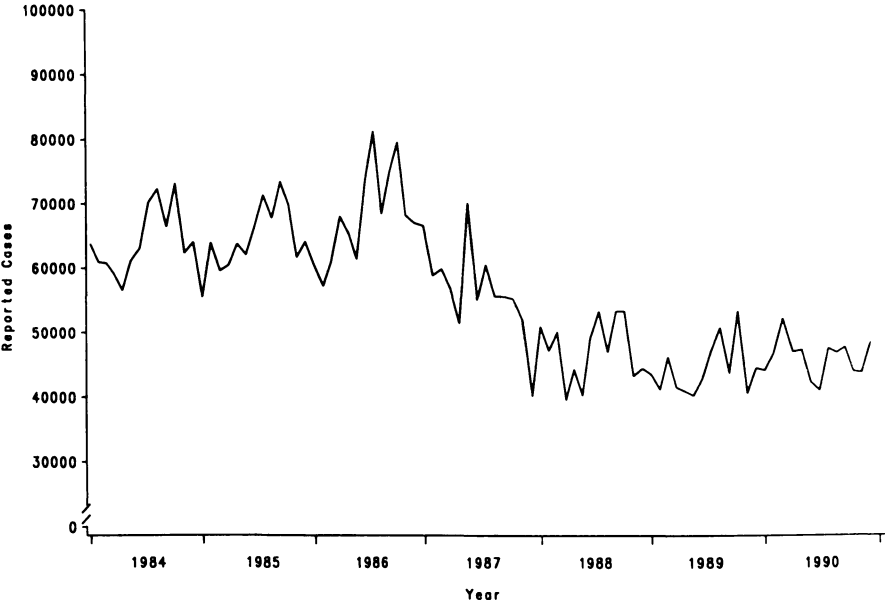
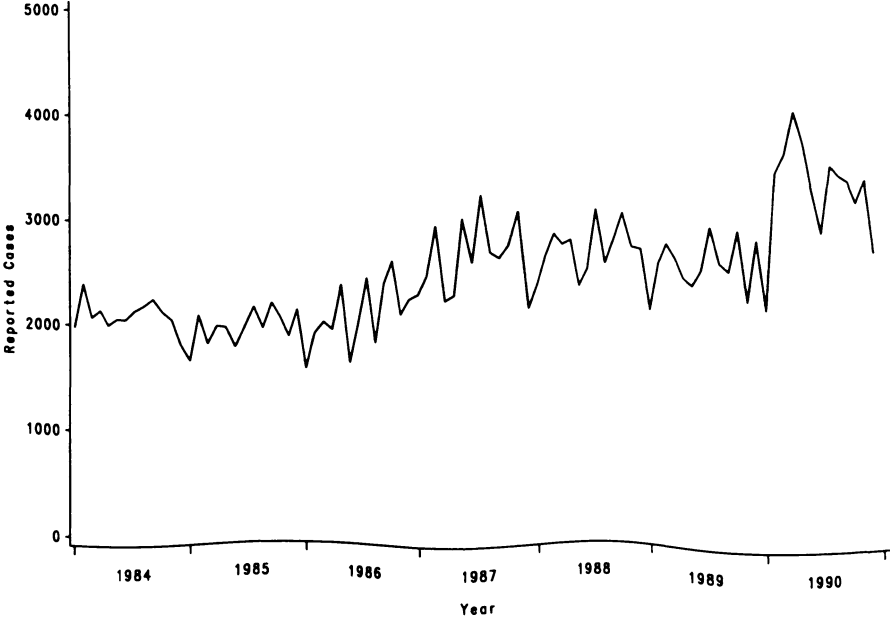


FIGURE V. Syphilis cases, by 4-week period of report — United States, 1984–1990



Meningococchemia – Continued

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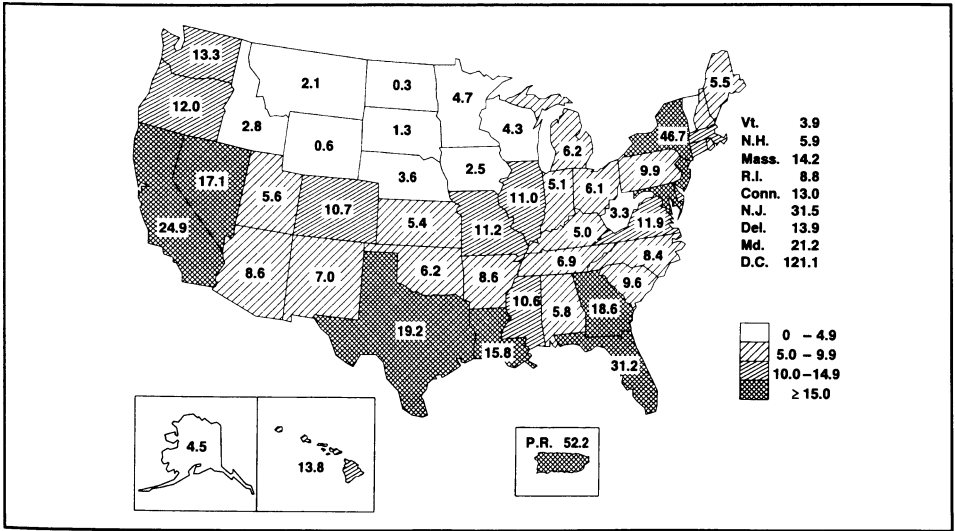
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Quarterly AIDS Map

The following map provides information on the reported number of acquired immunodeficiency syndrome (AIDS) cases per 100,000 population by state of residence for January–December 1990. The map appears quarterly in the *MMWR*. More detailed information on AIDS cases is provided in the monthly *HIV/AIDS Surveillance Report*, single copies of which are available free from the National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850; telephone (800) 459-5231.

AIDS cases per 100,000 population – United States, January–December 1990



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The data in this report are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday. Accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials, as well as matters pertaining to editorial or other textual considerations should be addressed to: Editor, *Morbidity and Mortality Weekly Report*, Mailstop C-08, Centers for Disease Control, Atlanta, Georgia 30333; telephone (404) 332-4555.

Director, Centers for Disease Control
William L. Roper, M.D., M.P.H.
Director, Epidemiology Program Office
Stephen B. Thacker, M.D., M.Sc.



Editor, *MMWR* Series
Richard A. Goodman, M.D., M.P.H.
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